

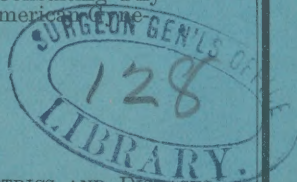
WILSON (H. P. C.)

A CASE
OF
COMBINED INTRAUTERINE AND ABDOMINAL
TWIN PREGNANCY;
THE FIRST CHILD BORN NATURALLY
AT EIGHT MONTHS;
THE SECOND DELIVERED ALIVE AT TERM BY LAPAROTOMY.

BY

H. P. C. WILSON, M.D.,

President of the Medical and Chirurgical Faculty of Maryland, and of the Baltimore Academy of Medicine; Gynecologist to St. Vincent's Hospital and the Union Protestant Infirmary; Consulting Physician to St. Agnes Hospital; Fellow of the American Gynecological Society, etc., etc., etc.



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A Case of Combined Intrauterine and Abdominal
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ON the 11th of May, 1880, I performed laparotomy at St. Vincent's Hospital in a case of abdominal pregnancy, and delivered a living male child weighing eight pounds.

The history of the case was as follows: Mrs. B., æt. 24, the wife of a carriage maker, has been delivered of three living children, at three births previous to the present pregnancy.

On the 15th of April, 1880, she was delivered of the fourth child, a girl (one month exactly, according to her calculation, before her expected confinement, which she said was due on the 15th of May). The appearance of the child, when I first saw it (three days after birth), confirmed the mother's statement, for it was evidently premature about that extent of time. Still it was healthy, and there was no apparent reason why it should not live with proper care. It was alive and doing well at the date of my operation. She was attended by an intelligent midwife, who says that she had a perfectly natural labor, and the afterbirth came away quickly and without any assistance. Mrs. B. and the midwife agreed, after the birth of the first, that there was a second

child within her, and as it did not make its appearance after waiting some time, they sent for Dr. F. Chatard, Jr. The doctor then called in his father, Dr. F. Chatard, Sr. (whose experience extends over fifty-five hundred cases of labor), and they agreed that the woman was pregnant with a second child, but they were undecided as to its exact habitation.

On the 18th of April (three days after her natural delivery), I saw Mrs. B. for the first time in consultation with Dr. F. Chatard, Jr. The patient was in as good condition as she could be after confinement. Had smart after-pains, but not excessive. Dr. Chatard gave her bromide of ethyl, and I passed my hand into the vagina, and further on, without difficulty, into the uterus, and I thus explored thoroughly. No child was there. I examined for a double uterus, but discovered nothing of the kind. I noticed at this examination that I could not touch the top of the uterus at its right upper angle to my entire satisfaction, and so stated to Dr. Chatard at the time. The uterus was very movable with my hand in it, and all its walls seemed to surround accurately my hand. My index finger in its explorations felt the uterine walls firm at every point, except at the right upper angle where the touch was unsatisfactory, and from this point I raked away a small piece of deciduous membrane. With one hand above the pubis, and the other in the uterus, the spherical uterine mass was clearly made out. When the abdominal tumor was moved, the uterus did not move with it. I was fully satisfied at this stage of the examination that, if this woman was pregnant, it was wholly extrauterine, and neither tubal or interstitial.

I then applied my ear to the abdomen, and in a moment discovered the sounds of the fetal heart. I listened carefully for the placental souffle, but could not detect the slightest sign of it, and oft-repeated auscultations could never discover it. I felt the movements of the child and felt it floating in fluid. As the tumor was movable without producing corresponding motion in the uterus, and the pelvis was free and the uterus empty, I was satisfied that the case was one of abdominal pregnancy. Drs. Wm. T. Howard and Alan P. Smith saw the patient with us some ten days afterwards, and agreed with Dr. Chatard and myself in our diagnosis.

During the twenty-three days from my first visit to the day of operation, I saw Mrs. B. occasionally with Dr. Chatard. We had agreed to carry her as near as possible to the time of expected confinement (May 15th) and then perform laparotomy in the interest of mother and child. During these twenty-three days, she had several attacks of pains simulating labor, which were quieted by opiates; and in passing I may remark that, whenever she was under anodynes, the child was perfectly quiet (evidently narcotized), and was not so active again till several days after the anodynes were omitted. In addition to incipient labor pains, she had in this time severe attacks of what she called "colic," requiring large and oft-repeated doses of morphia to ease her. From my first visit to the day of operation, her pulse varied from 95 to 110, and her temperature from 98 to 102°; usually lower in the

morning and higher in the evening. During this time she had much mental trouble, as her husband was on a drunken spree for three weeks and was still so on the day of operation. She lived in a malarious district. She was given quinine liberally, nourished well, given nervines, and had her vagina washed out daily with hot carbolyzed water.

On Monday (May 10th), she was taken to St. Vincent's Hospital, and on Tuesday (May 11th), I operated in the presence of Drs. F. Chatard, Jr. and Sr., Alan P. Smith, Wm. T. Howard, L. McLane Tiffany, Wm. B. Griffith, F. B. Gardner, B. B. Brown, T. A. Ashby, Jacob Houck, Augustus Erich, Wise, Porter, Lanier, and others. She was given a brisk purgative the day before the operation which thoroughly cleared the bowels. At 8 A.M. on the day of operation, she took five grains of quinine, and at 12 M., one grain of opium. She had a light breakfast and beef-tea at 11 A.M.

When everything was ready, at 1 P.M., she took a half-ounce of brandy, was placed on the table and given chloroform by Dr. F. B. Gardner (the room having been previously cleared of all persons but Dr. F. Chatard, Jr., Dr. Gardner, and myself). As there had been such diversity of opinion among my professional brethren as to the nature of this case, some contending it was a double uterus with a child in each; others that it was a cornual, tubal, or interstitial pregnancy; and none, except Drs. Chatard, Smith, and Howard, were willing to believe it an abdominal pregnancy; and as I had so vividly before my mind the recent case of my friend Dr. Goodell, in which he diagnosed extrauterine pregnancy, had appointed a day for the operation, and, in the meanwhile, the woman was taken in labor and delivered naturally of a living child, when she was found to have a double uterus; I determined, when fully anesthetized, to give the uterus a final digital examination. I therefore passed my hand into the vagina, and finding the os easily dilatable, carried it on into the uterus.

I could discover nothing but what I did at my first examination, but taking Simpson's sound, and guiding it by my hand in utero, I passed it up to the right angle of the uterus, and was surprised to find it pass on and on and on to the end of the handle and still did not touch bottom. I then took a much larger and longer sound and passed it in the same direction until its end touched bottom, well over on the right side and up under the lower surface of the liver, where it was distinctly felt by me and the other physicians present. I was nonplussed and at a loss to know where the sound had gone and what it was in. I began to feel that I had gotten into the other half of a double uterus, where the child might be, or into the Fallopian tube, and it was a tubal pregnancy; and some seemed to feel that I had pushed the sound through the top of the uterus, but I knew I had moved it too gently to have done that.

For some moments I was in doubt whether to go on with the operation or await further developments, and no one present

seemed able or willing to advise me; but being perfectly satisfied with my first diagnosis, although this sound manipulation was a stumbling block to me, I determined to proceed.

All the assembled physicians were invited into the room. I commenced my incision on the median line, three inches above the umbilicus, and carried it down and around the umbilicus, three inches below it. I cut carefully down to the peritoneum, and divided this on a grooved director. There was very little hemorrhage to this stage of the operation. A small cutaneous artery sprang, but it was instantly stopped by compression forceps, and gave no after-trouble. On entering the abdominal cavity, there was no escape of fluid, as is usually the case in ovariectomy. A tumor was before me exactly like an ovarian tumor. Feeling it with my finger, there was a hard, irregular mass floating within. Moving my index finger carefully over its surface, near the incision, I found it slightly adherent to the abdominal walls at some points, and very firm at others. In this very gentle manipulation, the walls of the tumor were so soft and fragile, that my finger ruptured them, and out poured a dirty yellowish fluid, evidently amniotic. The woman was instantly rolled over on her right side, and about a half-gallon was discharged into a bucket, in the hands of Dr. Tiffany. When all fluid had drained away, she was turned again on her back, my finger was passed into the rent, just large enough to admit it, and the child felt within. With a probe-pointed bistoury, guided by my finger in the rent, I ripped open the sac to the extent of the abdominal incision, and there presented the back and buttocks of the child. It was in a kneeling position, buttocks down, head up, thighs flexed on belly, and legs flexed on thighs, arms folded across the chest, and head bent forward (as if in the attitude of prayer), back towards the abdominal walls of the mother, and face and chest towards her spine.

I inserted the index finger of either hand into either groin of the child, and delivered in a few seconds (without the slightest difficulty) a boy weighing eight pounds. Dr. F. Chatard, Jr., received the child, while the index finger of my left hand was passed into its mouth, to make way for free admission of air to its lungs, and the palm of my right hand was applied actively to its buttocks. These means quickly set up feeble respiration, but no cry. The cord was tied by two ligatures, and cut between, and Dr. F. Chatard, Jr., took special charge of the child.

I then passed my hand into the sac which contained the child. Its thickness varied from one-sixth to one-tenth of an inch. It was firmly adherent to the abdominal walls in front and to the right, but very imperfectly adherent in front and to the left, but sufficient to prevent me, or any amniotic fluid, from gaining admittance to the abdominal cavity, especially as the woman was rolled to the right side. It was so fragile at the point of incision that I wondered why the child, in its motions, had not ruptured it before, and I can only account for this from the fact that at its weakened points the sac was strengthened by the abdominal walls.

On passing my hand to the bottom of the sac, and feeling for the uterus through its walls, I found the uterus of irregular shape and in an anomalous condition. The pelvic portion was enlarged and imperfectly contracted, as* was seen by the ease with which I passed my hand into it, just before commencing the operation. From the right upper angle extended a mass (about two inches in diameter) up to the under surface of the liver. It was evidently the structure into which I passed my sound, just before the operation began, and which perplexed me so much. The sac was attached to this, as well as that portion of the uterus just above the brim of the pelvis. The placenta was attached to the lower part of this mass. The uterus and this mass were one, as shown by moving them with my hand in the sac. I was doubtful for a moment whether this was an enlarged and dilated Fallopian tube, into which I so easily passed a sound, one-fourth of an inch in diameter and thirteen inches long, for its whole length; or whether it was the uncontracted uterus from which the first child had been so recently expelled, but it was evidently the latter; and I believe that the sac and placenta of the abdominal child, attached to that part of the uterus above the brim of the pelvis, acted as splints to prevent perfect contraction. The circular fibres of this portion of the uterus were contracted, and the longitudinal fibres not,—a sort of hour-glass contraction.

I attempted to locate the placental attachment, by following the cord; but this I found to be impossible, and desisted after very little exploration in this direction. I was unwilling to gratify my curiosity on this point, at the risk of separating some portion of the placenta, which I had already determined to leave undisturbed. All these explorations were made with my hand in the sac. I did not enter the abdominal cavity at all. The cord was brought out of the lower angle of the abdominal incision. The sac, where it was imperfectly attached to the abdominal walls, was sewed with a running whip-stitch to the edges of the abdominal incision, with carbolized silk. The abdominal incision was closed with six silver wire sutures, each suture passing through the edge of the sac. The lower angle was left open about an inch. The sac was thoroughly treated with carbolic spray, and cleansed with carbolized sponges before being closed. The whole operation was done under the antiseptic method. Everything was carbolized, and the spray constantly going.

To Dr. F. Chatard, Jr., is mainly due the salvation of the child after delivery, as its circulation and respiration were very imperfect for some time. He had it wrapped in raw cotton, artificial heat applied, stimulants given internally, and procured for it a wet-nurse after a few days. Nearly three months afterwards the child is well and thriving.

The operation was almost bloodless. The external wound was dressed with a piece of soft linen saturated with carbolized oil. The external portion of the cord was wrapped in linen wet with the same oil, and its ligature was made fast to the bandage around

the body. Over these was placed carbolized raw cotton, and over all, a muslin bandage.

The patient was then lifted carefully into bed, and put between blankets; and was given hypodermically at 3.30 P.M. 15 m of Magendie's solution of morphia. She was directed to be fed on ice, and nothing else was to pass her lips. Her temperature was 100° and pulse 104, half an hour before the operation; and temperature 100° and pulse 112 half an hour after the operation. The operation began at 1.30 and was finished at 2.40 P.M. She recovered well from the effects of the anesthetic, but within half an hour afterward began complaining of pains, in all particulars like after-pains. She so called them. These continued through the afternoon, notwithstanding the 15 m of Magendie hypodermically. They were only controlled after 6 P.M., when 25 m of Magendie were given under the skin. At 10 P.M., pulse was 130, temperature 103.6°, and respiration 28. Well under the influence of the anodyne, after-pains greatly relieved. Has had a good nap of sleep. Drew off two ounces of dusky urine. Skin hot. To be constantly sponged with cold water from head to foot. Plenty of ice by the mouth. No nausea up to this time.

May 12th, Wednesday, 8.15 A.M., pulse 120; temperature 101.6°; very slight after-pains. Has a troublesome cough, which shakes the abdomen greatly, and gives much distress from pain and soreness. The cough is controlled by the hypodermic injections of morphia, but returns when its effects pass off. Drew off five ounces of better-colored urine. Uterus injected with warm carbolized water, which brought away some small blood-clots. 20 m of Magendie given hypodermically. Continue ice by mouth, and cold-water sponging while the skin is hot and dry. 2 P.M., pulse 120, temperature 101°. Has been pretty comfortable since morning, except for the cough. About 11 A.M., after a spell of coughing, there was a discharge of dirty sanious fluid from the lower angle of the abdominal incision alongside the cord. This discharge continued from time to time on patient's coughing. Complaints of heartburn and some nausea, but has not vomited yet. Gave four ounces of milk per rectum, which was retained. Gave 20 m of Magendie hypodermically. Ordered to be kept under the influence of anodynes to restrain cough; to take twenty-five drops of McMunn's elixir of opium every two hours, if necessary, for this purpose. Washed out the sac with a syringe and carbolized warm water. To have four ounces of milk again at 6 P.M., which was given and retained. 9.30 P.M., pulse 132, temperature 102.2°, and respiration 42. Vomited twice since last visit; caused by the administration of twenty-five drops of McMunn's elixir by the mouth. Cough has been troublesome for the last hour, and distresses her dreadfully. Has slept a good deal through the day. Gave 28 m of Magendie hypodermically. Washed out sac and also the uterus with carbolized warm water. Wound looks healthy. Very little tympanites. Abdomen soft. Has passed urine once naturally since 1 o'clock. Gave four ounces of milk and one ounce of brandy into the rectum. Continue ice

by mouth and sponging as before. To repeat the enema of milk and brandy every four hours, and to add to the same fifty drops of McMunn's elixir if the cough is troublesome. May 13th, Thursday, 7.45 A.M., pulse 130, temperature 101.4°. Has passed a fair night under the influence of anodynes; cough not troublesome during the night; more so this morning. Has had two slight attacks of vomiting since 7 o'clock. Ejected a dark, bilious-looking fluid. At 8 A.M., took a half-ounce each of milk and lime-water by the mouth, and retained it. This is the first nourishment taken by the mouth since the operation. Complains much of heartburn. Has slight nausea at times. Took four ounces of milk, one and a half ounces of brandy, and fifty drops of McMunn's elixir by the rectum at 2.30 A.M., which she retained. At 6 o'clock this morning, the injection of milk and brandy and thirty drops of McMunn's was repeated, and retained. Passed urine involuntarily twice during the night, before the bedpan could be placed under her, although she had asked for it. Washed out the sac with carbolized warm water until the water came away clear. No unpleasant odor about the orifice. Drew off two ounces of clear but dark urine. Gave hypodermically 20 ℥ of Magendie; to have four ounces of milk and one and a half ounces of brandy every four hours by enema. Ice by the mouth; half-ounce of milk and half-ounce of lime-water by the mouth from time to time if desired and retained. Sponge the body freely with cold water when hot and dry. Abdominal wound dressed with carbolized oil and carbolized cotton. It looks well; no tympanites, abdomen soft; no pain of moment; patient's appearance improved; pulse stronger and better; respiration not over 30; expression of countenance more natural. At 2 P.M., pulse 136, temperature 103°. Washed out uterus. Drew off three ounces of dark urine. Patient more comfortable. 9 P.M., pulse 136, temperature 104.6°, respiration 36. At 6 o'clock, twenty-five drops of McMunn's elixir, one and a half ounces of brandy, and four ounces of milk were thrown into the rectum and retained; also half-ounce each of milk and lime-water was taken every two hours since 2 o'clock, and remained on the stomach. Vomited twice to-day between 7 and 2 o'clock; more restless; some subsultus, sighing, facies bad, some tympanites, wound looks healthy. Washed out sac with warm carbolized water. Its surface evidently is constantly secreting a dirty-looking serum. Gave 28 ℥ of Magendie hypodermically. Gave by enema one and a half ounces of brandy and four ounces of milk, and to be repeated every four hours; also milk and lime-water by the mouth as above, if relished and retained. Drew off four ounces of dark-colored urine. Cough better. Pulse weak and irregular. I had some difficulty in introducing a large, double, silver catheter into the sac beyond two or three inches. A mass, which we take to be placenta and sac, seemed to be crowding forward towards the lower angle of the incision.

Friday, May 14th, 7.30 A.M. Had a good night. Slept well most of the time since last visit. Took four ounces of milk and

as much lime-water by the mouth, and twelve ounces of milk and six ounces of brandy by the rectum, and retained them all. Expression of countenance good, cheerful, and inclined to joke. Had many wants, such as coffee, lemonade, etc.; the first time she has asked for anything to eat or drink since the operation. Passed her urine naturally in the night. Pulse 128, temperature 101.2°. Drew off a gill of urine this morning. Washed out the sac with warm carbolized water till it returned clear. Gave 20 m of Magendie hypodermically. Was sponged constantly through the night from head to foot with cold water, and has been thus sponged constantly. Her condition is greatly improved since yesterday, and I have strong hopes of her recovery. Has vomited slightly once since 10 o'clock last night.

2 P.M. Her condition changed in every way for the worse. Pulse 135; temperature 104. Much muscular jactitation. Respiration increased. Expression of countenance bad. Drew off four ounces of urine. Washed out uterus with carbolized warm water. Has had by enema twelve ounces of milk, four ounces of brandy, and twenty-five drops of McMunn's elixir, since 7.30 A.M. Skin hot; sponging constantly. Gave 15 m of Magendie hypodermically. —6 P.M. Was sent for to see Mrs. B., and met Drs. F. Chatard, Jr., and Alan P. Smith. Her condition much worse. Pulse 155, small and weak, and temperature 106.2. Countenance pinched. Every indication of approaching dissolution. A dirty, meat washing and offensive fluid issuing from the wound. The decaying sac was setting up a line of separation at some points, between itself and the abdominal walls. There was a bulging mass in front of the abdominal opening, which felt like the placenta making an effort to escape. We all felt that, unless the immense mass of decaying matter which was within the woman's abdomen could be removed speedily, she must inevitably die from blood poisoning, before it could be thrown off spontaneously. On consultation, it was determined to cut the stitches, and I carried my hand into the sac, through the gaping wound, and made an effort to deliver the placenta. The edges of the incision for its lower third were disunited. Those of the upper two-thirds were united, but easily gave way before the hand. I had hoped that enough time had elapsed to allow the separation of the placenta without much force or much hemorrhage. The commencing line of separation between sac and abdominal walls encouraged this hope; but I found the placenta so firmly attached that even my slight efforts at separation brought on so much hemorrhage, I was obliged to desist. In her weak state, she could not incur the loss of a small amount of blood without great danger to life. Firm pressure with large carbolized sponges arrested the hemorrhage. The gaping wound was filled in tightly with absorbing cotton, squeezed out of carbolized water, with a compress over this, and a bandage over all. We did not attempt to close the wound. The surface of the placenta, brought to view, presented a blue-black appearance, as also the walls of the sac. We gave her at this visit ten hypodermic syringes full of brandy,

under the skin. Pulse very quick and feeble—not to be counted. Two ounces of highly colored urine drawn from the bladder. Some odor emitted from the wound, in spite of frequent syringing with carbolized water. Gave two ounces of brandy, and six ounces of milk by enema. The rectum has retained milk and brandy remarkably well—never discarding them once.—9.30 P.M. Pulse not to be counted on account of feebleness and frequency. Temperature 102.6°. Coolness and jactitation of the extremities. Washed out the sac thoroughly with two quarts of carbolized warm water. Replaced fresh compresses of absorbing cotton, squeezed out of carbolic acid and water. Have given no hypodermic injection of morphia since 2 P.M. Gave four grains of hydrobromate of quinia under the skin, and six syringes full of brandy hypodermically.

Saturday, May 15th, Drs. Chatard, Smith, and I, met at 6 A.M., and I have neglected to state that I have had their valuable aid and counsel uninterruptedly since the operation. The patient has rallied since 11 last night, when we all expected to find her dead this morning. Pulse 138, stronger and better. Temperature 101.8. She was given an injection of milk and brandy into the rectum during the night, and I repeated it this morning, but the sphincter ani muscle had no retentive power, and they ran away as fast as thrown in. This has never occurred before. The rectum has retained the nutritive enemata with great comfort. Drew off two ounces of highly colored urine. Has taken by the mouth and retained comfortably eight ounces of milk and six ounces of brandy. Was a little nauseated once in the night. Asked for, and took, and enjoyed a cup of strong tea this morning. Gave hypodermically four grains of hydrobromate of quinia, and two syringes full of brandy in the same way. Washed out thoroughly the sac as before, and packed the gaping wound with cotton soaked in carbolized oil. The tympanites is great, so as to make the abdominal incision very patulous, and crowd the placenta and sac in front of the gaping wound. They present an ugly blue-black appearance, and are quite offensive. The whole appearance is that of an immense mass preparing to slough. The cord looks like one just before separating from a child, six or seven days after birth. The tympanites has forced the omentum down into the upper part of the wound. It is exposed to view about two and a half inches. No anodyne given since 2 P.M. yesterday. Slept some from time to time during the night. We left her at 7 A.M., encouraged to hope she might struggle through.

Mrs. B. died calmly and without a struggle, at 7.30 A.M., an half-hour after we left her, and ninety hours after the operation, her death at that time being unlooked for.

Two and a half hours after death, I made a post-mortem examination, assisted by Dr. F. Chatard, Jr., and Dr. Lanier. The abdomen was much distended by gas contained in the intestinal canal. There was no fluid in the abdominal cavity. There was no peritonitis—not even the usual congestion of this membrane, when any tumor is present within the abdomen. The intestinal

canal was particularly free from any congestive or inflammatory appearances, except where old adhesions to the sac were torn loose. The sac, which contained the child, was so firmly united to the abdominal walls on the right side, just below the floating ribs, that it was impossible to separate it therefrom. It was less firmly united to the abdominal walls in front and on the left, so that it could be separated without much difficulty. The sac was from one-sixth to one-tenth of an inch thick. It was firmly attached above to the omentum and to the transverse colon; on the left and behind, to the small intestines and descending colon; but at no point in this locality did it touch the abdominal walls. It was also attached on the right to the fundus of the uterus. Below it was attached to and covered the free surface of the placenta, and dipped down into Douglas' cul-de-sac.

The "afterbirth" consisted of three distinct placentas; not one mass with three lobes, but three separate masses, only united by membranes, on which three distinct sets of vessels, coming from a common cord, were conducted to each placenta. The umbilical vessels divided about two inches from the surfaces of these placentas, into three separate sets of vessels. From this point to navel of the child there was but one artery and one vein. One placenta was about as large as the other two together. It was about six inches in its long diameter, four inches in its transverse diameter, and two inches thick. The two smaller ones looked something like enlarged kidneys. The surfaces of attachment were small, in proportion to their size. The placentas looked like three masses, rolled up and bound together by membranes, and not like the flat, broad-brimmed slouch, that we usually see coming from the uterus. They were attached to the fundus and left side of the uterus, the left Fallopian tube, and upper part of the left broad ligament, and occupied the left side of the brim of the pelvis, and a portion of the left iliac fossa. They were entirely outside the Fallopian tube, and rested upon the top of it.

There was no indication of the slightest separation of the placentas. They were only separated from their attachments by considerable force, and with such separation there was a discharge of fully one and a half pints of very dark and apparently semi-watery blood. The largest of these placentas projected very prominently into the lower portion of the sac containing the child, and felt so elastic and so much as if it contained fluid, that it was suggested by some one present at the operation to puncture it. I was careful, however, not to do this, feeling sure it was placenta.

The umbilical cord passed over the top of this mass, running upwards and backwards, so that it gave the impression, on the first casual examination, that the placenta was attached somewhere under the stomach and spleen towards the spinal column; but when it came to be followed accurately after death, it was found that, after taking the above course, it dipped downwards behind this mass, and dividing into three distinct sets of vessels, was thus distributed to the three placentas.

The uterus occupied the right side of the brim of the pelvis, with its fundus slightly above it. While making the post-mortem, and before I had separated the attachments of sac and placenta, I attempted to pass my left hand into the cavity of the uterus, but only succeeded in inserting two fingers, and all my force did not enable me to get my hand in, although it was in the vagina; but by pressing down the fundus on my fingers, with my right hand above, I was able to measure the organ. A few moments before the operation began, I was enabled to insert my whole hand into the uterus with perfect ease. By these manipulations I could determine that the uterus was not half the size it was just before the operation, and could feel very certain that the pains which the patient had immediately after, and for twelve or fifteen hours after the operation, were none other than the after-pains which she called them and which we diagnosed them. With my hand in the uterus before the operation, and a sound (one-quarter of an inch thick and thirteen inches long) passed its whole length within the uterus, and with my hand in the sac after the removal of the child, by which I felt the uterus through the sac walls, it was demonstrated beyond controversy that the uterus was uncontracted in its long diameter, while it was partially contracted in the upper segment in its transverse diameter, but thus sufficiently contracted to prevent post-partum hemorrhage at the birth of the first child, when there was no unusual loss of blood.

No doubt the attachments of the sac and placentas to the left side and fundus of the uterus acted as splints to prevent the return of the uterus to its normal size after the birth of the first child, and until the delivery of the second child set the uterus free and allowed it to recede to its proper dimensions by the action of unrestrained after-pains. Moreover, by this manipulation with two fingers in the uterus, I was enabled to so move about the organ as to see its relations to sac and placentas before their removal.

The question arises as to the immediate cause of death in this patient. We left her at 7 A.M., after which she asked for, took, and enjoyed a cup of coffee. She then asked the nurse to raise her up in bed, when she suddenly turned blue in the face, her head fell back, and she expired in a few moments. Drs. Alan P. Smith, F. Chatard, Jr., and myself had left her thirty minutes before, thinking her better than she had been for sixteen hours. There is every reason to believe that septic poison was circulating in her blood, there was present every condition to produce it; but she did not die as I have always seen patients die with septicemia. She had no chill, no profuse sweats, no muttering delirium, no peculiar sweetish breath, no sudden and great rise of temperature (the greatest rise being three degrees in seven hours), and when it fell, it fell rapidly, not gradually, as in septicemia. Her mind was clear and calm up to the moment of death. She died suddenly and unexpectedly, more as if from embolism.

Thus the woman was lost, but her child was saved, and is to-day (nearly three months after delivery) a strong, healthy, hearty

boy. The girl, born naturally, died a little over a month after its birth, for no reason but the want of a mother's care and good nursing.

In the limited time allowed a busy practitioner to consult the literature on this subject, I have been able to find but one case similar to mine in its condition and termination, and that is the case of Dr. E. P. Sale, of Mississippi, published in the *New Orleans Med. and Surg. Journal* for Oct., 1870. Through the kindness of Dr. R. P. Harris, of Philadelphia, I am able to give an abstract of this case.

A negress, aged 22, single and a cripple from atrophy of the left leg, claimed that she had been tricked by a negro man and had a large snake in her abdomen, which she easily felt through the integuments, and the movements of which gave her great pain. Dr. J. W. Moore had been in attendance for about three weeks, when he called Dr. Sale on March 2d. They both diagnosed extrauterine pregnancy. At this consultation the woman weighed about 110 or 115 pounds. Respiration 37, temperature $97\frac{1}{4}^{\circ}$, and pulse 135, small and weak. The os uteri not dilated, cervix elongated, outline of uterus not definable under bi-manual exploration. She stoutly denied intercourse. Had had contractile pains for four weeks, believed to be threatened with rupture of an extrauterine cyst, is becoming rapidly emaciated.

Dr. Sale operated on March 3d. Incision to the left (of the median line) to suit the case. Hard and glistening tumor revealed; tried to determine its connection with the uterus by moving it, with the finger at the same time upon the os. It moved slightly, but the connection could not be made out. The cyst was so thin that the first cut of the knife opened it, blood gushed out, and the placenta soon came into view. This was extracted along with a living child, and the sac rapidly reduced itself in size and allowed the uterus, which it had almost entirely overlaid, to be felt. "To our great astonishment it was found to be large and globular, as if impregnated." In consultation with Dr. Moore it was decided to open the uterus, which being done, another living child, with its placenta, was removed. "The abdomen, cyst, and uterus were cleansed of all coagula, and the wound closed. A sound was passed, with some difficulty, through the os to allow the discharges to pass through."

"Prior to operation, four ounces of brandy were given, in the midst of the same, an injection of carbonate of ammonia, and at the close, 60 \mathfrak{m} of Batley's sedative, in two ounces of brandy. Pulse better after operation than before."

After-treatment by Dr. Moore, large doses of morphia, nutritious diet, and stimulants; wound dressed with carbolic acid and water.

March 4th, pulse 150, hiccough, lochia established.

“ 5th, “ 146, “ “ continued.

“ 6th, “ 140, “ “ “

“ 7th, “ 155, “(9 A.M.)“ “

Sanious discharge from the wound, complains of severe pains in arms and breast. Died of supposed septicemia at 3 P.M. No autopsy could be obtained. The woman lived three miles from Dr. Moore, and ten miles from Dr. Sale, with almost impassable roads at that season of the year, and both doctors, at the time, very busy. Both children were alive and doing well six weeks after the operation.

My attention has also been called by Dr. B. B. Brown, of Baltimore, to the case of Dr. Thomas R. Jessop, F.R.C.S., reported to the London Obstetrical Society, and published in the *Obstetrical Journal of Great Britain and Ireland*, Dec., 1876. This was a case of single abdominal pregnancy—not twins as in mine and Dr. Sales' case. Dr. Jessop's case was reduced to the verge of death at the time of operation, from much pain, sickness of stomach, and occasional discharges of blood from the uterus, through the whole pregnancy. (None of these symptoms present in my case; perfectly healthy up to the birth of first child.) All the prominent points of the child could be made out in his case; not so in mine—only a hard mass, floating in liquid. Placental souffle present in his case; none in mine. Ether used in his case; chloroform in mine. The position of his child and mine the same. No trace of cyst or membrane could be found in his case. My child was in a cyst, filled with fluid. The placenta covered the whole inlet of the pelvis, like the lid of a pot, and the umbilical cord entered its centre, as is usually the case. My placentas were three in number, occupied the left half of the brim of the pelvis and left iliac fossa, with a single umbilical cord, dividing into three cords, to supply each placenta. His child a girl; mine a boy. For an hour and a half there was much uncertainty about his child living, owing to defective respiration. The same was the case with mine, which was only saved by the untiring efforts of Dr. Chatard, Jr. Dr. Jessop thought this might be due to the child being etherized through the mother's blood. I think not. I have chloroformed too many women during labor, without seeing any unpleasant effects on their children. Wet-nurse procured for his child, also for mine. His child was found lying loose

among the intestines; no fluid in the abdominal cavity; all the viscera healthy. He did not interfere with the placenta. He operated as I did, and removed a living child. The child died twelve months afterwards of cholera infantum. The mother, after a hard struggle between life and death for months, made a perfect recovery.

Thus in these three cases of primary operation by laparotomy for extrauterine pregnancy, five lives were saved and two lives lost. Whereas, without the primary operation, all these lives would have been lost—four children and one mother saved; two mothers lost. My woman died from an accident; Dr. Sale's woman could have had very little attention, owing to the unfavorable circumstances in which she was placed. One of my twins was born naturally and alive, before the operation, and cannot be counted in the above statistics.

I strongly advocate the primary operation in all such cases, and not to wait till the sac ruptures, or the child dies.

To the above cases must be added that of Dr. Lawson Tait, in which he saved the child, but lost the mother on the fourth day. Also, Dr. Parvis' case, which died on the third day.

A case is also on record of a woman pregnant with twins—one child in the uterus, the other extrauterine. After the birth of child No. 1, she declined an operation for the second child, and died in about a month of ruptured cyst. This case occurred in North Carolina.

The London *Medical Times and Gazette*, for May 22d, 1880, contains three cases of extrauterine pregnancy, reported to the London Obstetrical Society; one by Dr. Braxton Hicks, and the other two by Dr. G. F. Fulcher. Dr. Hicks had diagnosed extrauterine pregnancy, of between six and seven months' standing; heard the fetal heart and a distinct placental souffle; was 29 years old, and had had two children. One day she was taken suddenly ill, and collapse and pallor speedily followed. He diagnosed internal hemorrhage, operated at once, found a large effusion of blood about the placental region, and delivered a large lifeless fetus of about six months. The placenta was attached to the abdominal wall in front, nearly up to the umbilicus, and did not touch the uterus or bladder. The child was contained in a

sac. Dr. Fulcher's first case was the wife of a cottager, 32 years of age, and this her third pregnancy. She was taken suddenly ill, and showed signs of internal hemorrhage. Extrauterine fetation, with rupture of sac, was diagnosed, and the patient died in a few hours. At the autopsy a fetus of about five months was found in the abdomen, with a detached placenta, whose attachment had been parietal. In his second case he diagnosed extrauterine pregnancy. He saw the patient Dec. 6th, and determined to have her removed to the Savernake Hospital, and there perform gastrotomy. There was some inexplicable delay. The fetal heart was heard up to the 12th; movements of the child continued till the 14th; she was removed to the hospital on the 16th; peritonitis set up on the 18th, and the operation was abandoned. She died on the 26th. The autopsy revealed a dead child, weighing nine and a half pounds. Placenta attached over left iliac fossa, left broad ligament, and abdominal wall up to linea alba.

One life, at least, was probably lost in this case, for want of prompt operation.

To my friend Dr. R. P. Harris I am indebted for reference to most of the above cases.

Extrauterine pregnancy is not of very rare occurrence, but the rarity consists in such cases going to term. The cyst that contains the fetus usually ruptures at about three months, and the patient is dead from internal hemorrhage before she or her physician is aware of her condition. Many of the cases of sudden death in women are due to this cause; and in the absence of autopsies, their attendants never know to what to attribute them.

A distinguished physician of Baltimore called on me some months ago, to know if I could explain the cause of sudden death in a perfectly healthy young married woman. She was at market, entirely well, in the morning, and so continued till the afternoon, when she was suddenly seized with violent pain in the lower abdomen, collapse and pallor speedily followed, and she was dead before night. She thought herself pregnant between two and three months, and so thought her physician. There was no autopsy; but I am sure this was a case of ruptured cyst in an extrauterine pregnancy.

Some eighteen months since, a patient of mine considered herself pregnant with her fourth child. I also considered her pregnant. In a little while she developed all the signs of extra-uterine, instead of intrauterine pregnancy. I felt a lump in Douglas' cul-de-sac to the right side. It was carefully watched—it was evidently growing. Her husband was prepared for a sudden death, as she approached the third month. When she reached two months, strong currents of electricity were passed through it for four or five days. It ceased to grow, soon began to diminish, finally disappeared, and the woman is now well.

